Print Form

Inland Orthopaedic Surgery & Sports Medicine Clinic

PATIENT INFORMATION

Please complete and bring with you to your appointment

DATE _____

Patient Name _____ Social Security # _____

Gender: ☐ M ☐ F Marital Status: ☐ S ☐ M Age _____ Birthdate _____

Address _____ City _____ ST ____ Zip _____

Phone Number _____ Work/Message Phone _____

Employer's Name/Address _____ Occupation _____

Spouse's Name _____ Spouse's Employer _____

Spouse's Social Security # _____ Spouse's Birthdate _____

STUDENTS/MINORS

Parent's Address _____

City _____ ST _____ Zip _____ Phone _____

Father's Name _____ Mother's Name _____

Social Security # _____ Social Security # _____

Employer's Name _____ Employer's Name _____

Phone Number _____ Phone Number _____

Date of Birth _____ Date of Birth _____

INSURANCE INFORMATION

(Please provide us with photocopies of your insurance cards)

PRIMARY INSURANCE FOR THIS VISIT _____

Mailing Address _____ City _____ St _____ Zip _____

Claim Phone Number _____ Subscriber's Date of Birth _____

SUBSCRIBER'S NAME _____

ID# / Claim Number _____

SECOND/OTHER INSURANCE NAME _____

Mailing Address _____ City _____ St _____ Zip _____

Claim Phone Number _____ Subscriber's Date of Birth _____

SUBSCRIBER'S NAME _____

ID# / Claim Number _____

Did a physician refer you to the clinic? If yes, please state whom: ______________________________

Are you seeing the doctor today because of an accidental injury? ☐ YES ☐ NO

Please check type of accident/injury: ☐ Work ☐ Auto ☐ Other Third Party

If accident occurred at work, who was employer? ______________________________

Please briefly describe how accidental injury happened: ______________________________

Date of Injury: ____________________ Date of Re-injury: ____________________

If injury is work-related, have you contacted your supervisor? ☐ YES ☐ NO

Have you filled out any necessary accident/injury reports? ☐ YES ☐ NO

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PLEASE READ

If my insurance requires a referral from my primary care physician, I understand it is my responsibility to contact my physician for a referral to the orthopaedic specialist I have chosen to see, prior to my visit. I will assume responsibility for, and payment of, any balances due should any services be denied for lack of referral from my primary care physician.

I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance.

NOTE: Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a sub stitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. If you are unsure about your coverage, please check your policy.

To the extent necessary to determine liability for payment, and to obtain reimbursement, I authorize disclosure of portions of the patient's record acquired in the course of the examination or treatment.

I hereby assign all medical and/or surgical benefits related to treatment from Inland Orthopaedics including Medicare, private insurance and other health care plans to: Inland Orthopaedic Surgery & Sports Medicine Clinic.

SIGNED ______________________________ DATE ____________________

IF PATIENT IS UNABLE TO SIGN, RELATIONSHIP TO PATIENT ____________________

(Parent, legal guardian)

This assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance.

-THANK YOU—
FOR FILLING OUT IN FULL!